

**FIG. 1**

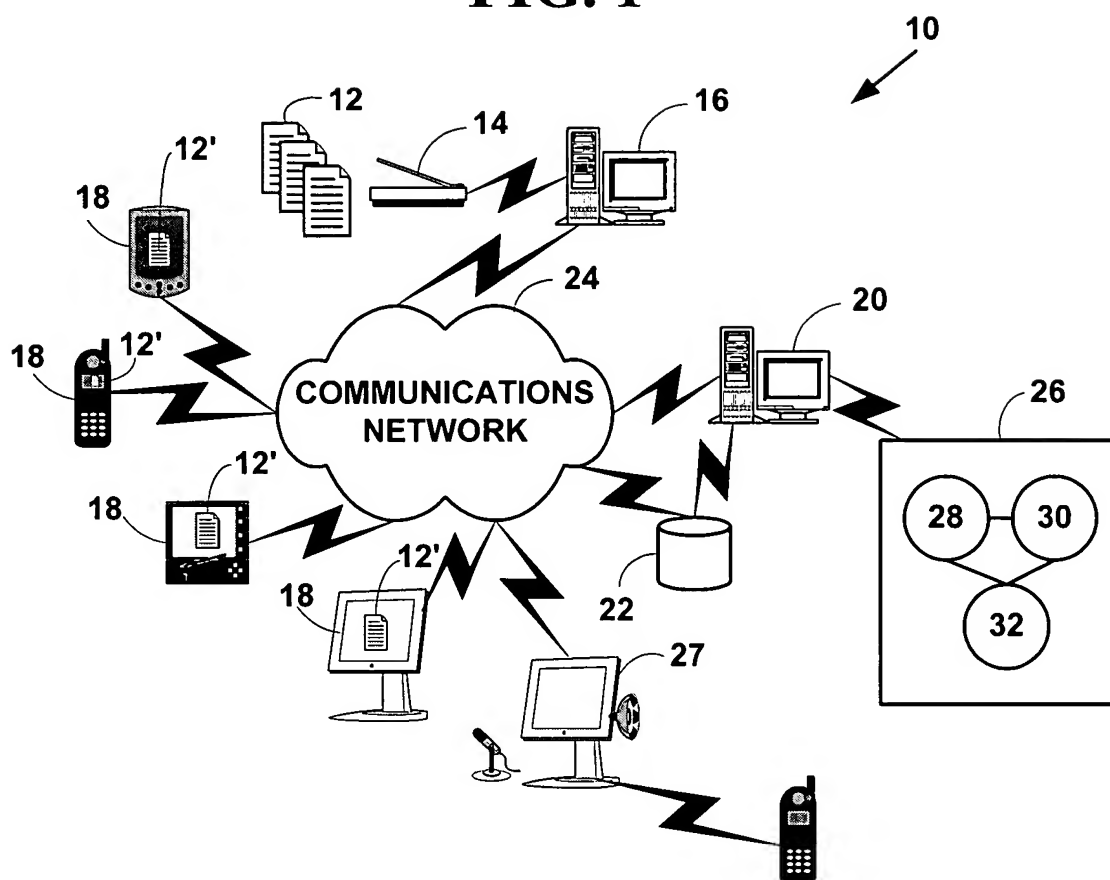


FIG. 2A

36
34

☐ Trend  
☐ Print

☐ First Name  
☐ Social Security / Patient Account Number  
☐ Today's Date (mm-dd-yy)

☐ MI  
☐ Date of Birth (mm-dd-yyyy)  
☐ Visit Time (hh-mm)

☐ Last Name  
☐ Date of Birth (mm-dd-yyyy)  
☐ AM  
☐ PM

General PIVOT™  
Ver. 0017 08/31/03

PV TEST PRACTICE 9999  
303A ANDREWS DR., BELVIDERE, IL 61008

☐ Cash  
☐ Rescan  
☐ No Code  
☐ Discard

**Main Problem (choose only one)**

☐ pain  
☐ numbness  
☐ swelling  
☐ other (specify)

☐ pressure  
☐ itching  
☐ congestion

☐ vomiting  
☐ diarrhea  
☐ cough

☐ nausea  
☐ anxiety/nerves  
☐ depression

Where is it? \_\_\_\_\_

For about how long? \_\_\_\_\_ hr \_\_\_\_\_ day \_\_\_\_\_ mo \_\_\_\_\_ yr

Worse when... \_\_\_\_\_

Better when... \_\_\_\_\_

It is... ☐ constant ☐ constant, worse at times ☐ comes & goes

List related symptoms... \_\_\_\_\_

How severe? (check one)   
0 1 2 3 4 5 6 7 8 9 10  
None pain or symptoms worst of your life

Additional Description \_\_\_\_\_

Was this a result of an injury? ☐ no ☐ yes (describe below) \_\_\_\_\_

Motor vehicle accident? ☐ no ☐ yes Work-related? ☐ no ☐ yes

**Recent Abnormal (for you) Symptoms**

Const	None	<input type="checkbox"/> stool <input type="checkbox"/> hard <input type="checkbox"/> loose <input type="checkbox"/> gas <input type="checkbox"/> weight loss
Neuro	<input type="checkbox"/> tingling <input type="checkbox"/> numbness <input type="checkbox"/> pain <input type="checkbox"/> dizziness <input type="checkbox"/> headache	<input type="checkbox"/> numb <input type="checkbox"/> tingling <input type="checkbox"/> urinary <input type="checkbox"/> sexual changes
Head	<input type="checkbox"/> pain in → <input type="checkbox"/> eye <input type="checkbox"/> ear <input type="checkbox"/> nose <input type="checkbox"/> throat	<input type="checkbox"/> ear ringing <input type="checkbox"/> nose discharge <input type="checkbox"/> hoarse voice
Eyes	<input type="checkbox"/> eye pain <input type="checkbox"/> double vision <input type="checkbox"/> eye pain	
Skin	<input type="checkbox"/> rash <input type="checkbox"/> hives <input type="checkbox"/> itching <input type="checkbox"/> skin	
Muscle-Skel	<input type="checkbox"/> muscle pain → <input type="checkbox"/> joint pain →	<input type="checkbox"/> muscle <input type="checkbox"/> joint <input type="checkbox"/> bone
Cardio	<input type="checkbox"/> chest pain <input type="checkbox"/> heart <input type="checkbox"/> blood	<input type="checkbox"/> heart <input type="checkbox"/> blood
Resp	<input type="checkbox"/> shortness of breath <input type="checkbox"/> cough <input type="checkbox"/> wheezing	<input type="checkbox"/> asthma <input type="checkbox"/> pneumonia
G.I.	<input type="checkbox"/> belly pain <input type="checkbox"/> diarrhea <input type="checkbox"/> nausea <input type="checkbox"/> vomiting	
Genito-Urinary	<input type="checkbox"/> painful or frequent urination <input type="checkbox"/> waking up to urinate	<input type="checkbox"/> sexual dysfunction <input type="checkbox"/> prostate <input type="checkbox"/> testicles
Endo	<input type="checkbox"/> extreme thirst <input type="checkbox"/> extreme hunger	<input type="checkbox"/> extreme thirst <input type="checkbox"/> extreme hunger
Psych	<input type="checkbox"/> depressed <input type="checkbox"/> nervous <input type="checkbox"/> anxious	<input type="checkbox"/> depressed <input type="checkbox"/> nervous <input type="checkbox"/> anxious
Heme	<input type="checkbox"/> glands swelling <input type="checkbox"/> unusual bleeding	
Allergy	<input type="checkbox"/> itchy eyes <input type="checkbox"/> sneezing <input type="checkbox"/> frequent colds	

**Medical Prob**

☐ None  
☐ heart disease  
☐ lung disease  
☐ diabetes  
☐ cancer (specify) \_\_\_\_\_  
☐ seizures  
☐ hay fever  
☐ high blood press

**Medications**

☐ None  

name

dose

freq

**Past Surgeries**

☐ None (surgery & date)  

name

date

**Family History: illnesses occurring before age 65**

Father ☐ none \_\_\_\_\_

Mother ☐ none \_\_\_\_\_

Siblings ☐ none \_\_\_\_\_

Children ☐ none \_\_\_\_\_

**Tobacco** ☐ never quit in (yr) \_\_\_\_\_ ☐ cigars

packs per day ☐ <1/2 ☐ <1 ☐ 1 ☐ 1 1/2 ☐ >2 ☐ chew or snuff

**Alcohol** ☐ never drinks per day ☐ <1 ☐ 1-2 ☐ 1 1/2 ☐ >2

**Illicit Drugs?** ☐ no ☐ yes

**Allergies (Document in boxes below)**

☐ Penicillin  
☐ Eggs  
☐ Shellfish  
☐ Latex

☐ Aspiration  
☐ Monitors  
☐ Anesthetics  
☐ Contrast

☐ Other \_\_\_\_\_  
☐ Other \_\_\_\_\_  
☐ Other \_\_\_\_\_

Pregnant? ☐ Yes ☐ No ☐ Unsure

Last Menses \_\_\_\_\_ (mm-dd-yy)


Last Tetanus Booster \_\_\_\_\_ (mm-dd-yy)

**Quality Verification**

☐ Sign in Complete

☐ Sign out Complete

☐ PIVOT™ Scanned

  
0001051  
36849

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- 38

<http://www.practicevelocity.com>

FIG. 2C

139

135

133

E/M-99203
History=DET (CC=COMP; HPI=COMP; PFMH=DET; ROS=DET)  
Exam=DET (13 Bullets & Systems) / Complexity of MDW=MOD (DX=MOD; RISK=MOD; Data=N/A)

☒ New  
☐ Ext  
☐ PIC  
☐ Conc  
☐ Trans  
☐ Pre-Surg  
☐ Phys  
☐ Zoph

First Name
MI
Last Name

Social Security / Patient Account Number
Date of Birth (mm-dd-yyyy)

Today's Date (mm-dd-yy)
Visit Time (hh-mm)

General PiVoT™  
Ver 0017-08/31/03

☐ Ccan  
☐ Rescan  
☐ No Code  
☐ Discard

**Main Problem (choose only one)**

☐ pain

☐ pressure

☐ vomiting

☐ nausea

☐ numbness

☐ itching

☐ diarrhea

☐ anxiety/nerves

☐ swelling

☐ congestion

☒ cough

☐ depression

Other (specify) chest

Where is it? chest

For about how long? 04 day 00 mo 00 yr

Worse when... afternoon

Better when... pt goes to bed

It is... ☒ constant ☐ constant, worse at times ☐ comes & goes

List related symptoms: chills, productive cough, yellow sputum, tightness in chest SOB

How severe? 0 1 2 3 4 5 6 7 8 9 10  
(check one) (no pain or symptoms) (worst of your life=10)

Additional Description

Was this a result of an injury? ☒ no ☐ yes (describe below)

Motor vehicle accident? ☒ no ☐ yes Work-related? ☒ no ☐ yes

**Recent Abnormal (for you) Symptoms**

Const	<input type="checkbox"/> fever	<input checked="" type="checkbox"/> chills	<input type="checkbox"/> sweats	<input type="checkbox"/> tired	<input type="checkbox"/> weight loss
Neuro	<input type="checkbox"/> headache	<input type="checkbox"/> weakness	<input type="checkbox"/> poor balance or coordination		
	<input type="checkbox"/> numb	<input type="checkbox"/> tingling	<input type="checkbox"/> urinary or bowel changes		
Head	<input type="checkbox"/> pain in →	<input type="checkbox"/> ear	<input type="checkbox"/> mouth	<input type="checkbox"/> tooth	<input type="checkbox"/> throat
	<input type="checkbox"/> pain hearing	<input type="checkbox"/> nose discharge	<input type="checkbox"/> nose discharge	<input checked="" type="checkbox"/> hoarse voice	
Eyes	<input type="checkbox"/> blurred vision	<input type="checkbox"/> double vision	<input type="checkbox"/> eye pain		
Skin	<input type="checkbox"/> insect bites	<input type="checkbox"/> rash	<input type="checkbox"/> itching		
Musc-Skel	<input type="checkbox"/> muscle pain →	<input type="checkbox"/> one area	<input type="checkbox"/> many areas		
	<input type="checkbox"/> joint pain →	<input type="checkbox"/> one joint	<input type="checkbox"/> several joints		
Cardio	<input type="checkbox"/> chest pain or pressure	<input type="checkbox"/> light headed	<input type="checkbox"/> fainting		
	<input type="checkbox"/> fluttering in chest	<input type="checkbox"/> swelling of legs or feet			
Resp	<input checked="" type="checkbox"/> short of breath	<input checked="" type="checkbox"/> cough	<input type="checkbox"/> wheezing		
G.I.	<input type="checkbox"/> belly pain	<input type="checkbox"/> diarrhea	<input type="checkbox"/> ataxia	<input type="checkbox"/> vomiting	
Genito-Urinary	<input type="checkbox"/> painful or frequent urination	<input type="checkbox"/> waking up to urinate			
	<input type="checkbox"/> sexual difficulties	<input type="checkbox"/> itching	<input type="checkbox"/> pain	<input type="checkbox"/> discharge	
	<input type="checkbox"/> irregular periods				
Endo	<input type="checkbox"/> often feel cold	<input type="checkbox"/> often feel hot			
	<input type="checkbox"/> overly tired	<input type="checkbox"/> overly thirsty			
Psych	<input type="checkbox"/> depressed/feeling blue	<input type="checkbox"/> anxious	<input type="checkbox"/> difficulty sleeping		
Home	<input type="checkbox"/> gland swelling	<input type="checkbox"/> unusual bruising			
Allergy	<input type="checkbox"/> itchy eyes	<input type="checkbox"/> sneezing	<input type="checkbox"/> frequent infections		

4 days hx Chest Congestion Cough

**Medical Prob**

☒ None  
☐ heart disease  
☐ lung disease  
☐ diabetes  
☐ cancer (specify)  
☐ seizures  
☐ hay fever  
☐ high blood press

**Medications**

☐ None  

OTC Tussing

Tylenol

**Past Surgeries**

☒ None (surgery & date)

**Family History: illnesses occurring before age 65**

Father ☐ none

Mother ☐ none

Siblings ☐ none

Children ☐ none

**Tobacco** ☐ never ☐ quit in (yr)      ☐ cigars

packs per day ☐ <1/2 ☒ <1 ☐ 1 ☐ 1 1/2 ☐ >2 ☐ chew or snuff

**Alcohol** ☒ never ☐ drinks per day ☐ <1 ☐ 1-2 ☐ 1 1/2 ☐ >2

**Illicit Drugs?** ☒ no ☐ yes

**Allergies (Document in boxes below)**

NKDA

Pregnant? ☐ Yes ☐ No ☐ Unsure

Last Menses      -      -      (mm-dd-yy)

Last Tetanus Booster      -      -      (mm-dd-yy)

**Quality Verification**

4000 → 873 → 0808

Sign in Complete

Sign out Complete

PiVoT™ Scanned

0021219

35849

FIG. 2D

137

40

First Name		MI	Last Name	Date of Birth (mm-dd-yyyy)	Gen	Px																																																
T 9824P 78		BP	140/82	10/18/03																																																		
VSx3		R	Wt. (lbs)	Ht.																																																		
<input checked="" type="checkbox"/> General appearance <input checked="" type="checkbox"/> Conjunctivae & Eyelids <input type="checkbox"/> PERRLA (symmetrical) <input type="checkbox"/> Ophthalmoscopy (disc sz, C/M, look, vessel, fund, bleed) <input checked="" type="checkbox"/> Pinnae & Nose (appearance, scar, lesion, mass) <input checked="" type="checkbox"/> Otoscopy (TMs and ECs) <input checked="" type="checkbox"/> Hearing (e.g., whisper, finger rub, tuning fork) <input checked="" type="checkbox"/> Nares (mucosa, septum, turbinates) <input checked="" type="checkbox"/> Mouth (lips, teeth, gums) <input checked="" type="checkbox"/> Pharynx (mucosa, saliv glands, palate, tongue, tonsils, post.) <input checked="" type="checkbox"/> Exam (mass, appearance, symmetry, trachea, crepitus) <input type="checkbox"/> Thyroid (enlargement, tenderness, mass) <input checked="" type="checkbox"/> Effort (retraction, access, muscles, diaphragm movement) <input checked="" type="checkbox"/> Auscultation (breath sounds, crackles, rales) <input type="checkbox"/> Percussion (dullness, flatness, hyperresonance) <input type="checkbox"/> Palpation (eg, tactile fremitus) <input type="checkbox"/> Auscultation (abnormal sounds, murmurs) <input type="checkbox"/> Palpation (PMI location, size, thrills) <input type="checkbox"/> Carotids (pulse amplitude, bruits) <input type="checkbox"/> Abdominal aorta (size, bruits) <input type="checkbox"/> Femoral arteries (pulse amplitude, bruits) <input type="checkbox"/> Pedal pulses (pulse amplitude) <input type="checkbox"/> Extremities (edema, varicosities) <input type="checkbox"/> Inspection (symmetry, nipple discharge) <input type="checkbox"/> Palpation (include axillae: mass, lump, tender) <input type="checkbox"/> Masses or Tenderness <input type="checkbox"/> Liver & Spleen <input type="checkbox"/> Anus, Perineum, Rectum (sph. tone, hemorrhoid, mass) <input type="checkbox"/> Stool sample for occult blood <input type="checkbox"/> Hernia <input type="checkbox"/> External & Vagina <input type="checkbox"/> Urethra <input type="checkbox"/> Bladder <input type="checkbox"/> Cervix <input type="checkbox"/> Uterus <input type="checkbox"/> Adnexa & Parametria <input type="checkbox"/> Inspection <input type="checkbox"/> Palpation <input type="checkbox"/> CNS 2-12 <input type="checkbox"/> DTR's <input type="checkbox"/> Sensation <input type="checkbox"/> Judgement & Insight <input type="checkbox"/> O x 3 <input type="checkbox"/> Memory (remote and recent) <input type="checkbox"/> Mood & Affect <input type="checkbox"/> Gait & Station <input type="checkbox"/> Digits: inspection & palpation (clubbing / cyanosis)																																																						
<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>front</p> </div> <div style="text-align: center;"> <p>back</p> </div> </div> <p>right left left right</p> <p>41</p> <p>Care of Patient</p> <p>None of the above</p> <p>With mild symptoms</p> <p>Check for signs</p> <p>Check for signs of heart or lungs</p> <p>Check for signs</p>																																																						
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Diagnoses</th> <th>Select 1 highest box!</th> <th>In Global Period</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> new (w/o pending)</td> <td><input type="checkbox"/> life threat; chr prb (sev exac)</td> <td><input type="checkbox"/> day 1; 0-10d global</td> </tr> <tr> <td><input checked="" type="checkbox"/> new (w/o complete)</td> <td><input type="checkbox"/> acute neuro change (TIA, sz, weak, or fracture (manipulation))</td> <td><input type="checkbox"/> day 1; 90d global</td> </tr> <tr> <td>est <input type="checkbox"/> recur <input type="checkbox"/> exac</td> <td><input checked="" type="checkbox"/> Rx mod; chr prb (mild exac)</td> <td><input type="checkbox"/> day 1; sched. proc.</td> </tr> <tr> <td>est <input type="checkbox"/> recur <input type="checkbox"/> exac</td> <td><input type="checkbox"/> acute prb (syst. sx or compl)</td> <td><input type="checkbox"/> routine flu to global</td> </tr> <tr> <td><input type="checkbox"/> est (stable)</td> <td><input type="checkbox"/> head injury brief LOC, 2 chronic problems, or fracture (no manipulation)</td> <td><input type="checkbox"/> complication</td> </tr> <tr> <td><input type="checkbox"/> est (stable)</td> <td><input type="checkbox"/> OTC med; minor surg.</td> <td><input type="checkbox"/> related procedure</td> </tr> <tr> <td><input type="checkbox"/> est (stable)</td> <td><input type="checkbox"/> acute problem (uncomplic.) or 1 chronic problem (stable)</td> <td><input type="checkbox"/> unrelated problem</td> </tr> <tr> <td><input type="checkbox"/> minor <input type="checkbox"/> new/recur</td> <td><input type="checkbox"/> minor prob. rest, gags...</td> <td><input type="checkbox"/> previous procedure</td> </tr> <tr> <td><input type="checkbox"/> minor (reg. visit, minor, minor)</td> <td><input type="checkbox"/> (e.g. add. pneumonia, recent flu)</td> <td><input type="checkbox"/> different provider</td> </tr> </tbody> </table>							Diagnoses	Select 1 highest box!	In Global Period	<input type="checkbox"/> new (w/o pending)	<input type="checkbox"/> life threat; chr prb (sev exac)	<input type="checkbox"/> day 1; 0-10d global	<input checked="" type="checkbox"/> new (w/o complete)	<input type="checkbox"/> acute neuro change (TIA, sz, weak, or fracture (manipulation))	<input type="checkbox"/> day 1; 90d global	est <input type="checkbox"/> recur <input type="checkbox"/> exac	<input checked="" type="checkbox"/> Rx mod; chr prb (mild exac)	<input type="checkbox"/> day 1; sched. proc.	est <input type="checkbox"/> recur <input type="checkbox"/> exac	<input type="checkbox"/> acute prb (syst. sx or compl)	<input type="checkbox"/> routine flu to global	<input type="checkbox"/> est (stable)	<input type="checkbox"/> head injury brief LOC, 2 chronic problems, or fracture (no manipulation)	<input type="checkbox"/> complication	<input type="checkbox"/> est (stable)	<input type="checkbox"/> OTC med; minor surg.	<input type="checkbox"/> related procedure	<input type="checkbox"/> est (stable)	<input type="checkbox"/> acute problem (uncomplic.) or 1 chronic problem (stable)	<input type="checkbox"/> unrelated problem	<input type="checkbox"/> minor <input type="checkbox"/> new/recur	<input type="checkbox"/> minor prob. rest, gags...	<input type="checkbox"/> previous procedure	<input type="checkbox"/> minor (reg. visit, minor, minor)	<input type="checkbox"/> (e.g. add. pneumonia, recent flu)	<input type="checkbox"/> different provider																		
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																		
<p>Legend: <input type="checkbox"/> normal <input type="checkbox"/> abnormal (abnormal specified)</p> <p>Provider: _____</p> <p>36849</p> <p>http://www.practicevelocity.com</p>																																																						

**FIG. 3**

FIG. 3

42

44 46 NECK 40 48

● ☐ ☐ EXAM (MASS, APPEARANCE, SYMMERTY, TRACHEA, CREPITUS)

● ☐ ☐ THYROID (ENLARGEMENT, TENDERNESS, MASS)

GREEN RED

50

41

DIAGNOSES

☐ NEW (W/U PENDING)
 ☐ NEW (W/U COMPLETE)
 

EST ☐ RECUR ☐ EXAC
 

EST ☐ RECUR ☐ EXAC

☐ EST (STABLE)
 ☐ EST (STABLE)
 ☐ EST (STABLE)
 

☐ MINOR ☐ NEW/RECUR
 

☐ MINOR
 

(e.g, cold, tinea, or insect bite)

FIG. 4

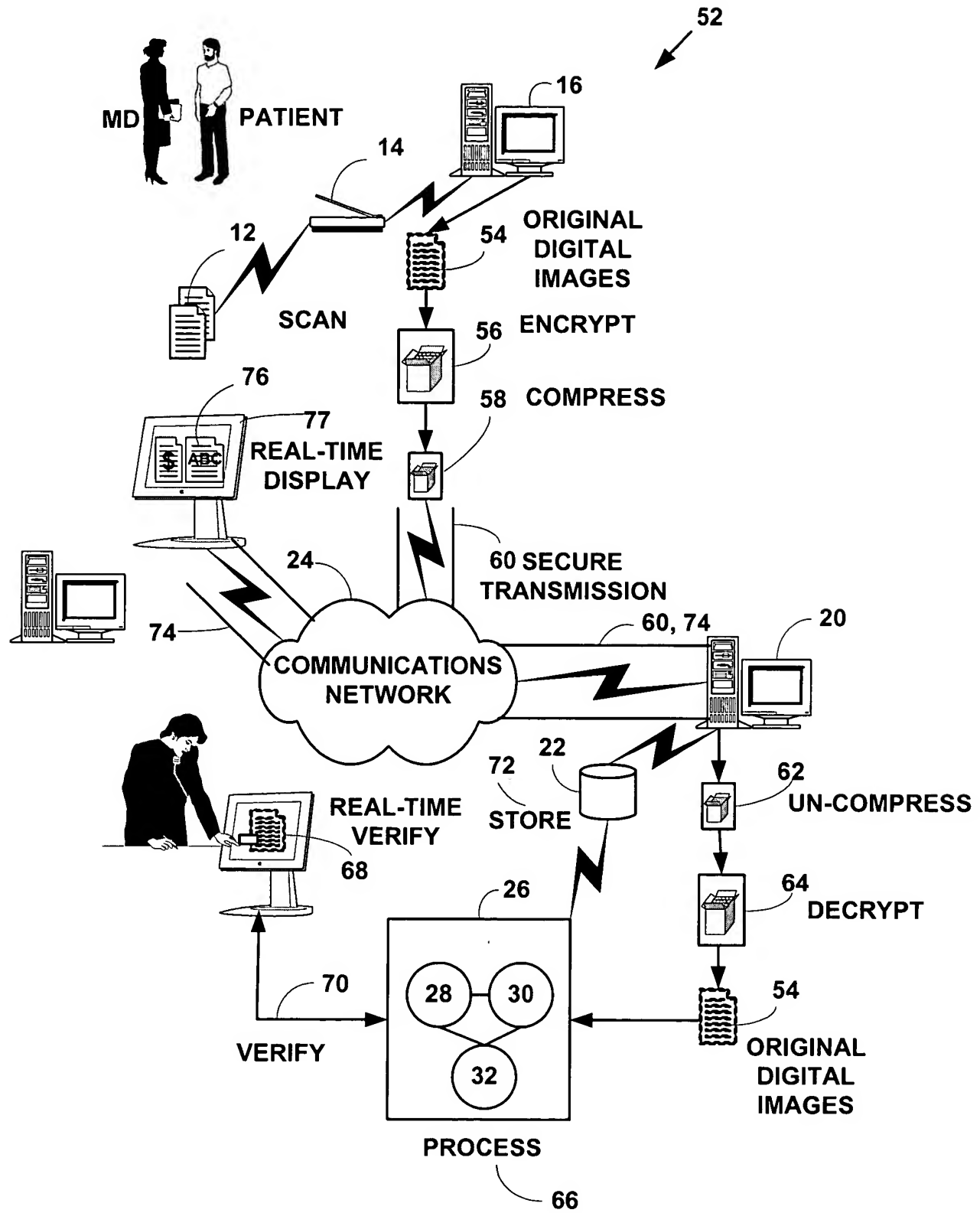
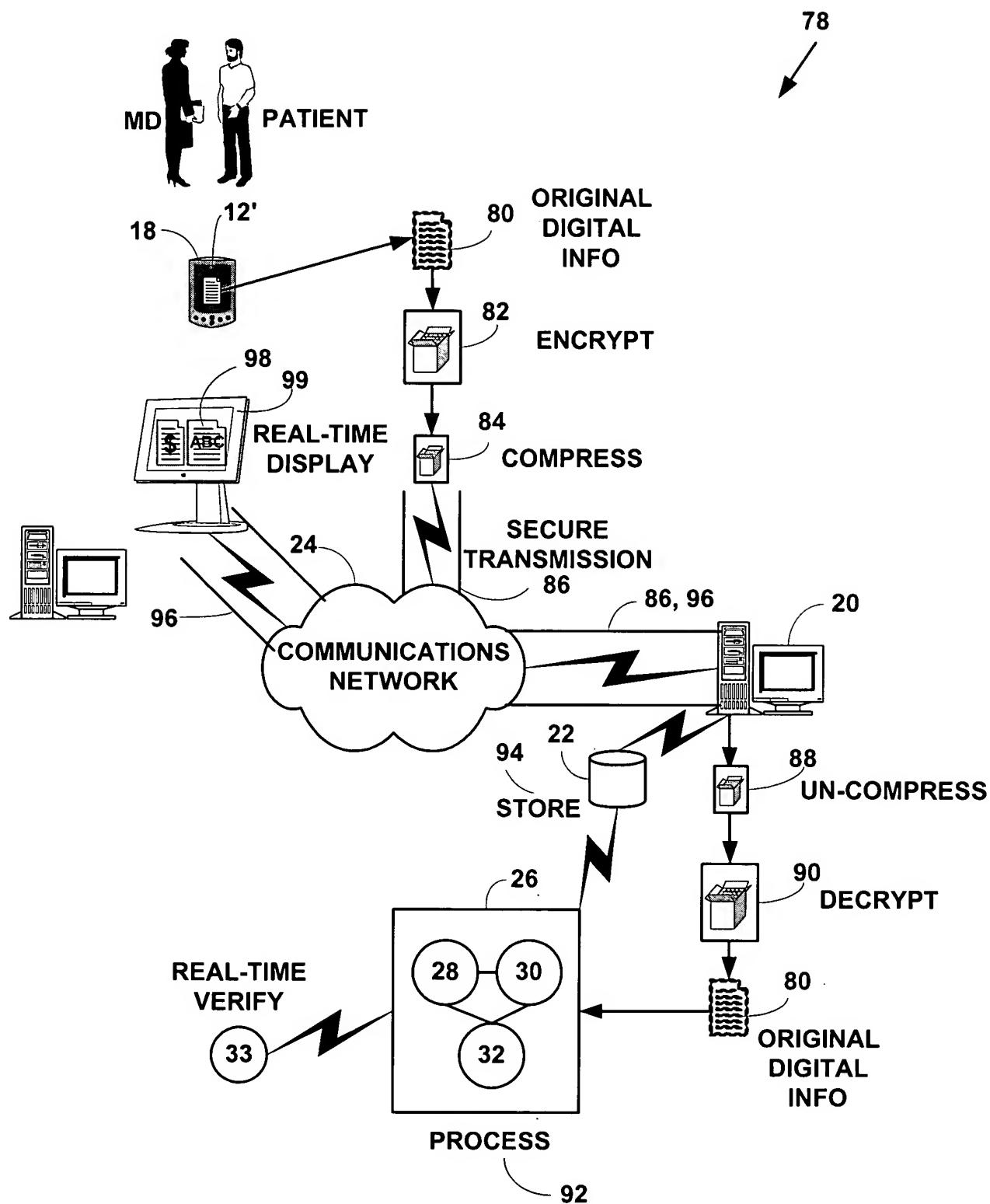
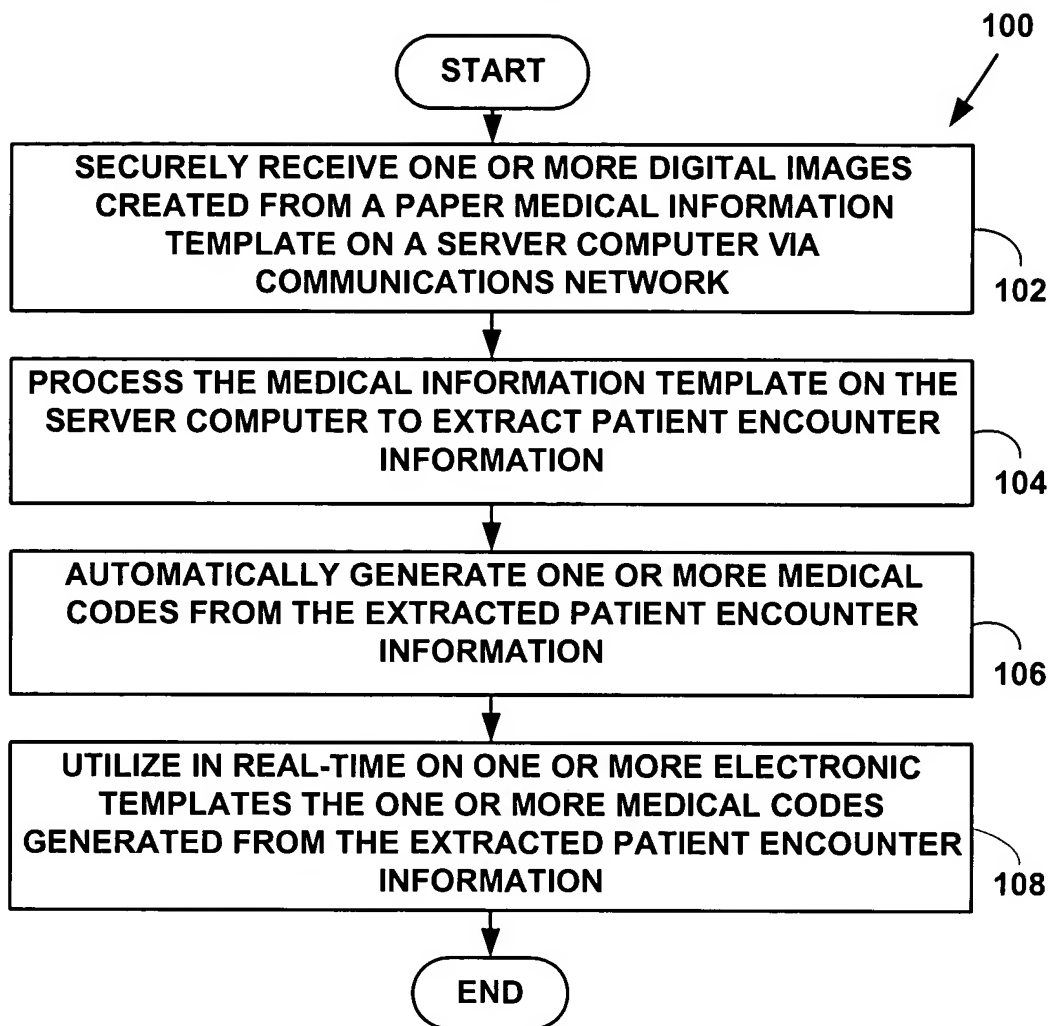


FIG. 5

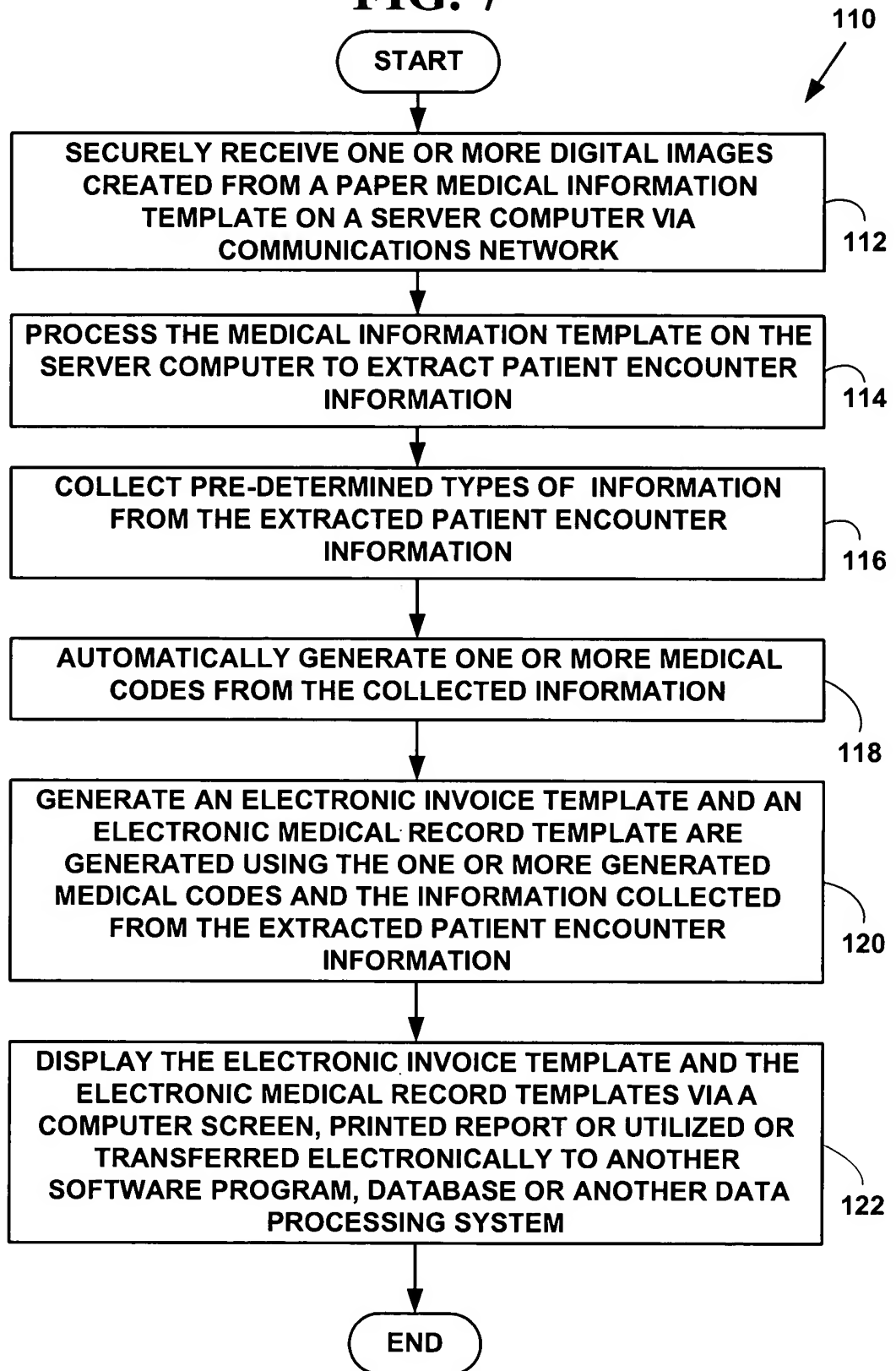




**FIG. 6**



**FIG. 7**





# FIG. 11

**Final E/M** NEW OUTPATIENT

130

	99201	99202	99203	99204	99205
HX	PF	EXPF	DET	COMP	COMP
PX	PF	EXPF	DET	COMP	COMP
CX	SF	SF	LOW	MOD	HIGH

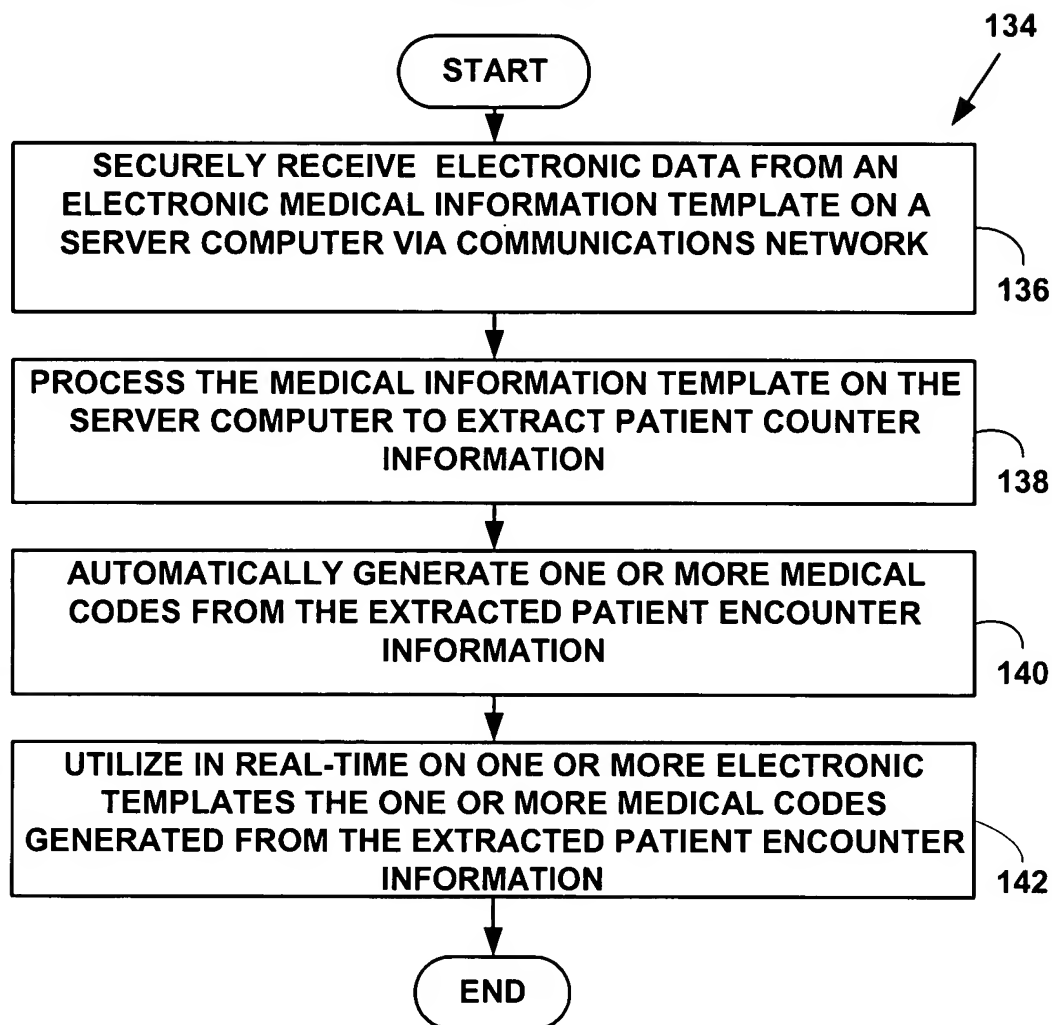
# FIG. 12

**Final E/M** ESTABLISHED OUTPATIENT

132

	99212	99213	99214	99215
HX	PF	EXPF	DET	COMP
PX	PF	EXPF	DET	COMP
CX	SF	LOW	MOD	HIGH

**FIG. 13**



**FIG. 14**

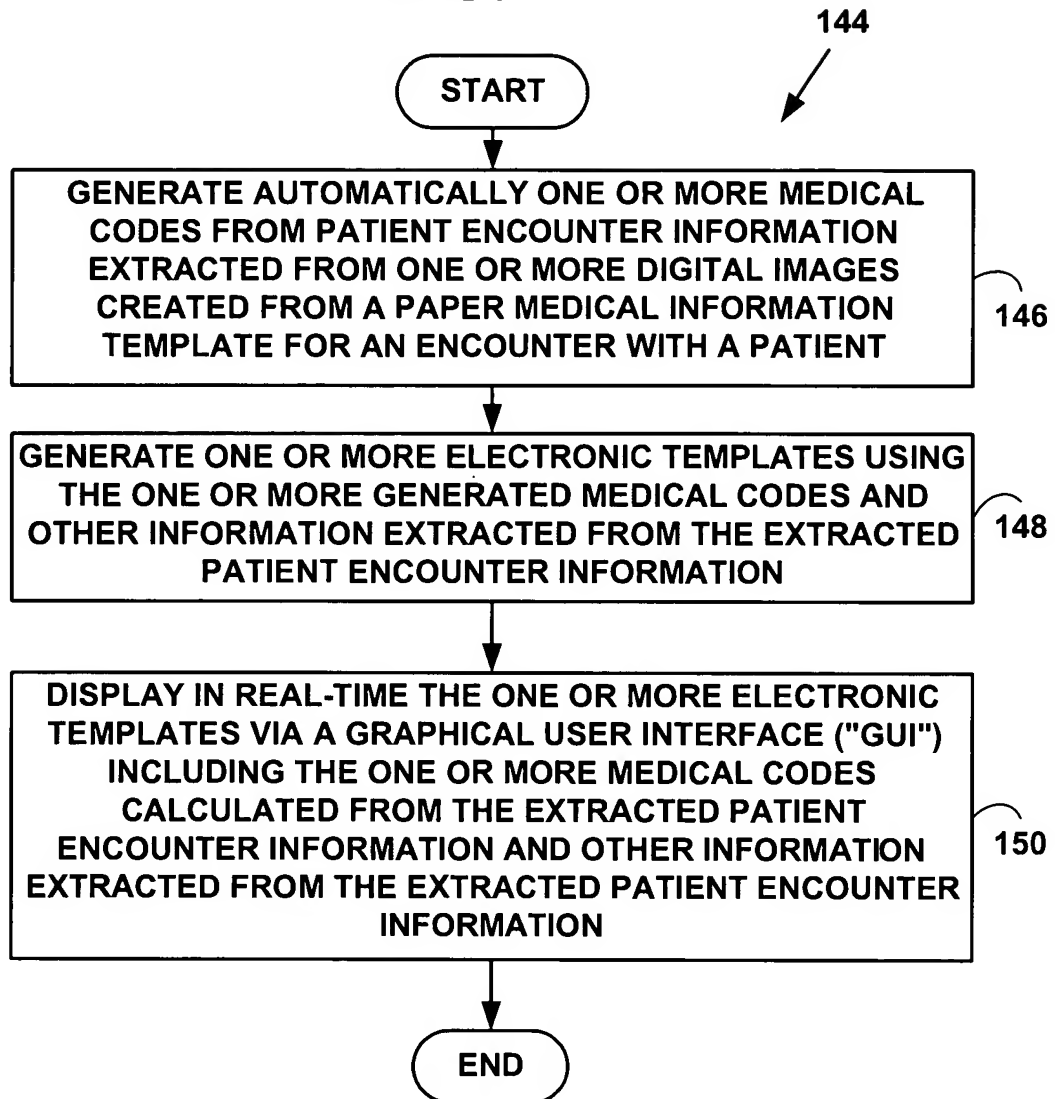


FIG. 15

